1933

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County New Madrid

Township Como

or

Village

or

City Parma (NO. ..... St.; ..... Ward)

Registration District No. 605 File No. 2494

Primary Registration District No. 5804 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lucinda Hull

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: 2 (Month) 14 (Day) 1864 (Year)

7 AGE: 69 yrs. 11 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeping 93 58
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country): Illinois

PARENTS

10 NAME OF FATHER: Henry Ford

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Illinois

12 MAIDEN NAME OF MOTHER: Unknown Holland

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): USA

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William S. Hull

(Address) Parma Mo

15

Filed Jan 25, 1933. Mrs C S Blackman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 25th (Day) 1933 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 21, 1933, to Jan 25, 1933, that I last saw her alive on Jan 25th, 1933, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-Carditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malaria

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Best M. D.

..... 191.... (Address) Parma-Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Saddler Cemetery

DATE OF BURIAL: Jan 26, 1933

20 UNDERTAKER: T. C. Knight

ADDRESS: Parma Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE
.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.
....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....

20 UNDERTAKER	ADDRESS